

United States District Court
District of Massachusetts

Marlow Williams Sr.
Plaintiff

v.

City of Boston et al
Defendants

Civil Action
No. 01-12346-MLW

Witnesses to be Subpoenaed For the Plaintiff

1. Herman Walker of 38 Coleman St. Boston, MA. 02122
Mr. Walker is the owner of the home where the "Plaintiff's" allegations occurred on Feb. 4, 2003, and was present at the time of the incident, and witnessed this assault
2. Edward Payne of 38 Coleman St. Boston, MA. 02122
Mr. Payne is the son of Mr. Walker, and also lived at the home. He was present on Feb. 4, 2003 at the time of the incident, and witnessed this assault
3. David Vincent of 345 Quincy St. Dorchester, MA. 02122
Mr. Vincent is a close friend of Mr. Walker and was also arrested on Feb. 4, 2003. He was present at the time of the incident and witnessed this assault on Mr. Williams
4. The Plaintiff's expert witnesses shall be designated by July 1, 2004.

Respectfully Submitted,
Pro se Plaintiff,
Marlow Williams Sr.
Marlow Williams

10/7/05 Kendrick Lurey
5991934
2C7

Nelle W. Palmer
Gen Sessions St 201

Derry Bell
5127057
4L66

Court of Criminal Appeals
Supreme Court Bldg. 46 Hwy 4
45 by Pass POBx 909
Jackson TN 38302

10/10/05 Edward Barnes
5128955
5A2

Amy Mayne, P.D.

Melvin Elam
5106331
DECK5

Amy Mayne, P.D.

Marlow Williams
4189052
1B7

U.S. District Court
1 Courthouse Way Ste 2300
Boston MA 02210

Brian Harris
5111044
1F11

Wharton Firm
Ste 1205, 147 Jefferson Ave

Gerald Barry
5115749
6A10

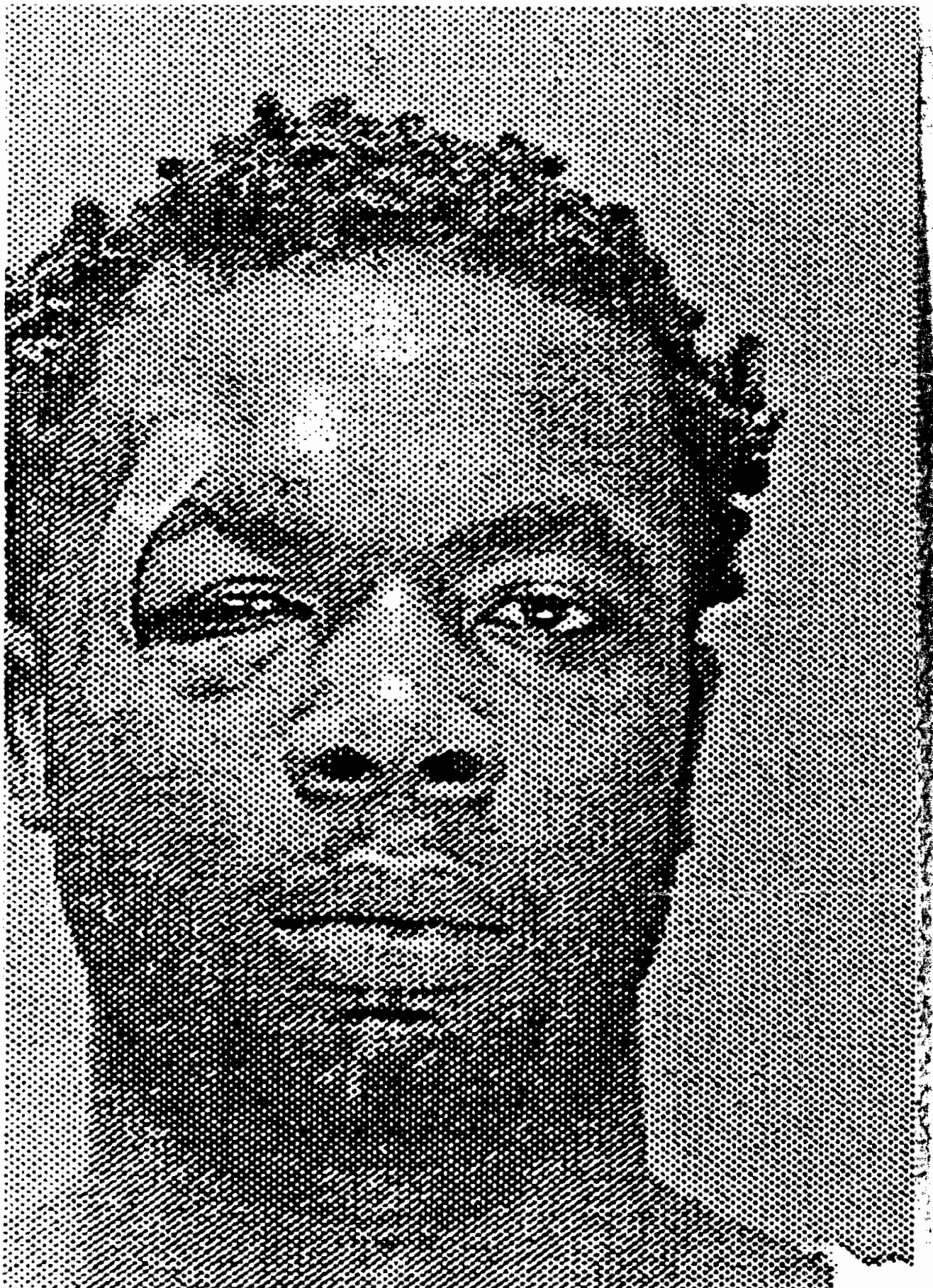
P Patten Brown II, Asst Fed Def
Federal Public Def
200 Jefferson Ave Ste 200

Kasey Campbell
3120813
1F7

L. Sue Burrow Asst P.D.

Christopher Smith
5104372
1G14

Atty Glenda Adams



Enter Emergency Patient PA: 61264043
 Admit Dt/Tm: 02/04/03 15:27 Hosp Svc: EAA MR #: 2087716
 ExpA Dt/Tm:
 Nurs St: Rm/Bed: Pt Sts: ET PT Type: E
 ----- Patient Allergy Information In System As Of 02/04/03 15:27 -----

----- Patient Demographic Information -----
 Name = WILLIAMS ,MARLOW SSN: 019-58-2111
 Addr = 8 LYFORD ST #3 Addr2:
 City = DORCHESTER St: MA City: St:
 Zip: 02124- Ph: 617-822-0724 Zip: Ph:
 DOB: 09/19/1976 Adm Sc: EO Adm Pr: X Arr Md: A
 Age: 26 Sex: M Disaster#: Pos ID: N
 Lang = ENGLISH DX/CC/PR:
 Interp Needed: N
 Race: 2 MS: S Rel: UNK RFV: D MEDICAL VISIT
 Adv Directive executed: Adv directive provided:
 Comments: D/I VER 2/4/03 KS

----- Physician/Transfer Information -----
 Atn Dr: STEPHEN, JAMES Res Dr:
 Ref Dr: PCP: NONE
 Ref Add: PCP Add:

Ph: Fx: Ph: - - Fx: - -
 Trf Facility: Trf Tel No:

----- Primary Contact Information -----
 Name: NO ,ONE Rel To Patient: U UNKNOWN
 Addr:
 City: St: Zip:

Hme Ph: Work Ph: Ext:
 ----- Secondary Contact Information -----
 Name: Rel To Patient:
 Hme Ph: Work Ph: Ext:

----- Guarantor Information -----
 Lst Name: WILLIAMS First Name: MARLOW Rel To Pat: S
 Addr: 8 LYFORD ST #3 - SELF
 City: DORCHESTER St: MA Zip: 02124- Ph: 617-822-0724
 Employr: UNEMPLOYED Ph: Ext:
 Addr:
 City: St: Zip:

----- Employer Information -----
 Empl: UNEMPLOYED Occupation: UNEMPLOYED
 Addr:
 City: St: Zip: Ph:

----- Insurance Information -----
 1) PATIENT PAY Cd: P50 Pri: 1 2) Cd: Pri:
 Pol #: 1 Pol #:
 Grp #: Grp #:
 Auth#: Auth#:
 Subscr: WILLIAMS ,MARLOW Subscr:
 Sub SSN: 019-58-2111 Rel: SELF Sub SSN: Rel
 Ph: - - Cert: Ph: - - Cert:
 3) Cd: Pri:
 Pol #:
 Grp #:
 Auth#:
 Subscr:
 Sub SSN: Rel:
 Ph: - - Cert:
 Prereg/Reg/Preadm/Adm by: / KXS112 /


Tufts-New England Medical Center

830 Washington Street
Boston, Massachusetts 02111
Telephone (617) 636-5566

208 17 1h
AC 61264043
WILLIAMS, MARLOW
EAA, STEPHEN, JAMES
09/19/1976 H
02704703

OBST

EMERGENCY DEPARTMENT ADULT NURSING FLOW SHEET

PATIENT'S NAME: <u>Marlow Williams</u>		AGE: <u>26</u>	DOB: <u>09-19-76</u>
TIME: <u>1:30</u>	DATE: <u>02-04-07</u>	MOA: <u>SELF</u>	ALB: <u>+</u>
PRESENTING COMPLAINT: <u>cc: facial lacer. + (R) eyebrow + facial hematoma;</u>		PRIVATE PHYSICIAN	FAMILY PRESENT <input type="checkbox"/>
NURSING ASSESSMENT: <u>pt involved in altercation. LOC. & neuro deficit</u> <u>evidence of ETOH. Dries neck, upper back pain.</u> <u>Does c/o LS pain.</u> <u>(pt acc. by BPD - under arrest)</u>			
<input type="checkbox"/> DV Screen		LAST TETANUS: <u>Nov. 02</u>	LMP: <u></u>
PRESENT MEDICATIONS: <u></u>		WEIGHT: <u></u>	HEIGHT: <u></u>
ALLERGIES: <u>MRDA</u>		O ₂ SAT: <u>98%</u>	
PERTINENT MEDICAL HISTORY: <u></u>		BP: <u>130/85</u>	HR: <u>85</u>
		RR: <u>18</u>	T ₃₆ : <u>96°</u>
		<input type="radio"/> No Hurt <input type="radio"/> Hurts Little Bit <input checked="" type="radio"/> Hurts Little More <input type="radio"/> Hurts Even More <input type="radio"/> Hurts Whole Lot <input type="radio"/> Hurts Worst	
ACUITY: <u>2</u>	RETURN VISIT DATE: <u></u>	SERVICE: <input type="checkbox"/> PSYCH <input checked="" type="checkbox"/> ADULT <input type="checkbox"/> EXPRESS <input type="checkbox"/> REFERRAL	TRIAGE R.N. SIGNATURE: <u>R. M. R.</u>

PRIMARY ASSESSMENT

AIRWAY	C-SPINE	BREATHING	CIRCULATION	DISABILITY / NEURO
<input checked="" type="checkbox"/> PATENT <input type="checkbox"/> NON-PATENT <input type="checkbox"/> ORAL-NASAL AIRWAY <input type="checkbox"/> INTUBATED ET SIZE: <u></u> <input type="checkbox"/> cmat lit <input type="checkbox"/> SUCTIONED SECRETIONS	<input checked="" type="checkbox"/> NO PAIN / DISABILITY <input type="checkbox"/> PAIN <input type="checkbox"/> BACK BOARD <input type="checkbox"/> CERVICAL COLLAR <input type="checkbox"/> DISABILITY <input type="checkbox"/> MECHANISM of INJURY	<input checked="" type="checkbox"/> WNL <input type="checkbox"/> ASSISTED <input type="checkbox"/> BVM <input type="checkbox"/> NRB <input type="checkbox"/> LUNG SOUNDS <input type="checkbox"/> VENTILATOR: FiO ₂ <u></u> Vt <u></u> Rate <u></u> PEEP <u></u> <input type="checkbox"/> NC @ <u></u> L/min	<input checked="" type="checkbox"/> WNL <input type="checkbox"/> PULSELESS <input type="checkbox"/> THREADY PULSES <input type="checkbox"/> ASHEN <input type="checkbox"/> CYANOTIC <input type="checkbox"/> PALE <input type="checkbox"/> DIAPHORETIC <input type="checkbox"/> CAP REFILL > 2 sec <input type="checkbox"/> CPR (See Code Sheet) <input type="checkbox"/> IV ACCESS <input type="checkbox"/> IV PUMP Line #1 <u></u> g <u></u> site. SL or <u></u> @ ml/hr. Line #2 <u></u> g <u></u> site. SL or <u></u> @ ml/hr.	<input type="checkbox"/> NONE <input type="checkbox"/> RESPONDS to VERBAL <input type="checkbox"/> RESPONDS to PAIN <input type="checkbox"/> UNRESPONSIVE <input type="checkbox"/> GCS <input type="checkbox"/> ONSET of SYMPTOMS

SECONDARY ASSESSMENT

HEAD/EENT	CHEST	ABDOMEN
<input type="checkbox"/> WNL <input checked="" type="checkbox"/> VISUAL ACUITY R <u>20/40</u> <input type="checkbox"/> PUPIL SIZE R <u></u> mm L <u></u> mm <input type="checkbox"/> DEFORMITY <u>(R) eye - swelling</u> <input checked="" type="checkbox"/> SWELLING	<input type="checkbox"/> WNL <input type="checkbox"/> PAIN <u></u> / 10 <input type="checkbox"/> QUALITY <u></u> <input type="checkbox"/> RADIATING <input type="checkbox"/> DYSRHYTHMIA (Attach Strip) U/S <input type="checkbox"/> ABSENT <input type="checkbox"/> WHEEZES <input type="checkbox"/> RALES <input type="checkbox"/> RHONCHI Location: <u></u> Peak Flow <u></u> O ₂ Sat <u></u> % on RA or <u></u> L <input type="checkbox"/> CREPITUS <input type="checkbox"/> WOUND (Describe) <input type="checkbox"/> O ₂ <input type="checkbox"/> MONITOR <input type="checkbox"/> ECG <input type="checkbox"/> ANALGESIA <input type="checkbox"/> NEBULIZERS (See Asthma Flow Sheet) <input type="checkbox"/> NITRATES <input type="checkbox"/> tPA <input type="checkbox"/> HEPARIN <input type="checkbox"/> ANTIARRHYTHMICS	<input type="checkbox"/> WNL <input type="checkbox"/> PAIN LOCATION <input type="checkbox"/> BS Absent, Hypoactive, Hyperactive <input type="checkbox"/> DISTENDED <input type="checkbox"/> RIGID <input type="checkbox"/> GUARDING / REBOUND <input type="checkbox"/> STOOL / EMESIS GUAIAC POS <input type="checkbox"/> NAUSEA <input type="checkbox"/> VOMITING <input type="checkbox"/> DIARRHEA <input type="checkbox"/> CONSTIPATION <input type="checkbox"/> LAST nt BM <u></u> / <u></u> <input type="checkbox"/> NGT <u></u> Fr <input type="checkbox"/> PLACEMENT CHECKED <input type="checkbox"/> ANALGESIA <input type="checkbox"/> DRESSINGS

GU / GYN	EXTREMITIES	PSYCHOSOCIAL
<input type="checkbox"/> WNL <input type="checkbox"/> PAIN <input type="checkbox"/> BLEEDING at MEATUS <input type="checkbox"/> HEMATURIA <input type="checkbox"/> DYSURIA <input type="checkbox"/> FREQUENCY <input type="checkbox"/> INCONTINENT <input type="checkbox"/> BIRTH CONTROL: Type <u></u> <input type="checkbox"/> VAG BLEEDING / DISCHARGE <input type="checkbox"/> # of PACS / HR <u></u> <input type="checkbox"/> LMP <u></u> / <u></u> / <u></u> <input type="checkbox"/> EDC <u></u> / <u></u> / <u></u> <input type="checkbox"/> FOLEY <u></u> Fr <input type="checkbox"/> STRAIGHT CATH <u></u> ml <input type="checkbox"/> U/A <input type="checkbox"/> C & S <input type="checkbox"/> UCG <input checked="" type="checkbox"/> FHS <input type="checkbox"/> LOCATION <u></u> <input type="checkbox"/> RATE <u></u>	<input type="checkbox"/> WNL <input type="checkbox"/> PAIN <input type="checkbox"/> SWELLING <input type="checkbox"/> DEFORMITY <input type="checkbox"/> WOUNDS (See Injury Location Sheet) <input type="checkbox"/> ABNORMAL ROM Site: <u></u> <input type="checkbox"/> PERIPHERAL PULSES PRESENT <input type="checkbox"/> LIMP <input type="checkbox"/> ATAXIC <input type="checkbox"/> SPLINTED <input type="checkbox"/> ELEVATED <input type="checkbox"/> ICE <input type="checkbox"/> ANALGESIA <input type="checkbox"/> CRUTCHES <input type="checkbox"/> KNEE IMMOBILIZER <input type="checkbox"/> AIR SPLINT <input type="checkbox"/> CSM	<input type="checkbox"/> WNL Accompanied by <u></u> <input type="checkbox"/> Community / Family Supports: <u></u> <input type="checkbox"/> PSYCH HX <input type="checkbox"/> DEPRESSION <input type="checkbox"/> BIPOLAR <input type="checkbox"/> SUICIDAL <input type="checkbox"/> HOMICIDAL <input type="checkbox"/> ETOH ABUSE <input type="checkbox"/> DRUG ABUSE <input type="checkbox"/> SECLUSION <input type="checkbox"/> RESTRAINTS (See Restraint Flow Sheet) <input type="checkbox"/> SITTER <input type="checkbox"/> DETOX REFERRAL <input type="checkbox"/> WITHDRAWAL PROTOCOL <input type="checkbox"/> SOCIAL SERVICE CONSULT <input type="checkbox"/> DV SCREEN DONE Abused by <u></u> Relationship <u></u> <input type="checkbox"/> PHYSICAL ABUSE <input type="checkbox"/> SEXUAL ABUSE <input type="checkbox"/> EMOTIONAL ABUSE <input type="checkbox"/> JANE DOE BED <input type="checkbox"/> SAFETY PLAN

SIGNATURE: <u>R. M. R.</u>	DATE: <u>02-04-07</u>
----------------------------	-----------------------

☐ ICD code
☐ Chart Done
☐ Secretary initials
☐ Discharge time

NEURO/PSYCH

☒ oriented ☒
☒ mood / affect nml
☒ no sensory / motor deficit
☒ CN's intact as tested

slow / disoriented
 confused / obtunded
 weakness / sensory loss
 facial droop / EOM palsy / anisocoria

abnormal gait
 ataxic

CHEST

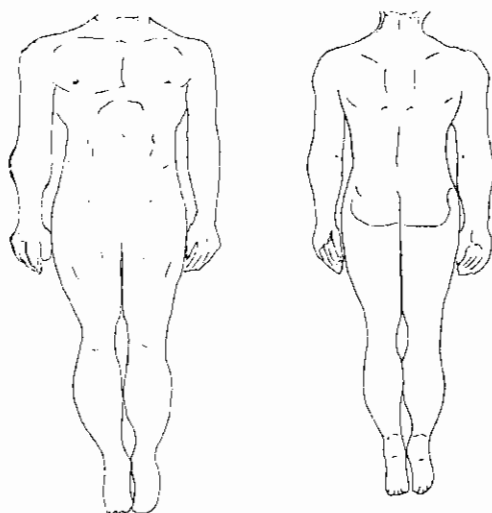
☐ non tender

ABDOMEN

☐ non tender

EXTREMITIES

☐ non tender



XRAYs

☐ Interp. by me ☐ Reviewed by me ☐ Discd w/radiologist

C-Spine

nml / NAD reversal / straightening of cerv. lordosis
 no fracture DJD / spondylosis / spurring
 alignment
 soft tissues nml

Facial Series

nml / NAD soft-tissue swelling
 no fracture max. sinus opacification / air-fluid level
 soft tissues nml
 sinuses nml

Other ☐ See separate report

CT SCAN

normal

PROCEDURES and PROGRESS:

Wound Description/Repair

length 1.75 cm location (R) Eyebrow
 superficial ☒ linear ☐ stellate ☐ contused tissue
 irregular ☐ through-and-through
 muscle ☐ flap ☐ lip laceration
 clean ☐ contaminated minimally / moderately / *heavily

distal NV: ☐ neurovascular status intact

anesthesia: Local LET / TAC
☒ lidoc 1% 2% epi / bicarb ☐ marcaine .25% .5%

prep:

Shur-Clens / Betadine ☐ debrided
☒ irrigated / washed with saline ☐ minimal / ^mod. / ^extensive
 minimal / mod. / ^extensive ☐ undermined
☐ wound explored ☐ minimal / mod. / ^extensive
☐ foreign material removed ☐ ^wound margins revised
 partially completely ☐ *vermillion border aligned
 minimal / mod. / ^extensive ☐ ^multiple flaps aligned

repair: Wound closed with: wound adhesive / steri-strips
 SKIN- # 4 6 -0 (nylon) prolene / staples
 *SUBCU- # -0 vicryl / PDS

*may indicate intermediate repair ^may indicate intermediate or complex repair

CT Scan head - 0 fracture, 0 Air-Fluid
 levels in sinuses
 Some STS over sinuses
 lower laceration care sheet head
 injury sheet. Return in 5 days for
 follow up.
 Resident or PA (MD) / DO / PA

FACULTY:

not seen / examined ☒ resident's hx reviewed
 HX-PT ARRIVES VIA EMS. 90% FACIAL
 INJURY FROM FISTICUFFS. LOC
 PX- W.D.W.N. BOY. NAD. ALERT
 (+) LAC. (+) EYEBROW AREA. (+) CONT
 SUPRAORBITAL RIM. CT (+)

referred to / discussed with Dr.

will see patient in: office / ED / hospital in days

Rx given

CLINICAL IMPRESSION:

Contusion 3 Hematoma head ORBIT. facial nose chin mouth	Laceration 2 scalp forehead facial periorbital nose	Concussion with LOC without LOC Acute Cervical Myofascial Strain
---	---	---

① ACUTE TRAUMA EXAM

DISPOSITION- ☒ home ☐ admitted ☐ transferred
 TIME
 CONDITION- ☐ unchanged ☒ improved ☐ stable

MD/DO/PA
 Attending
☐ Addendum ☒ Template Completed

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New England Medical Center

A Lifespan Partner

750 Washington Street
Boston, Massachusetts 02111
Telephone: (617) 636-5000

EMERGENCY PHYSICIAN RECORD

Facial or Head Injury (4)

03

02 04 03

TIME SEEN: 4:15 ROOM: OBS ☒ EMS ArrivalHISTORIAN: ☒ patient ☐ spouse ☒ paramedics

AGE: 26

Hx/ EXAM LIMITED BY:

HPI chief complaint: injury to:

☒ head ☐ face ☐ mouth / lip / chin / nose ☐ neck

occurred:

☒ just prior to arrival☐ today☐ yesterday

____ days PTA

where:

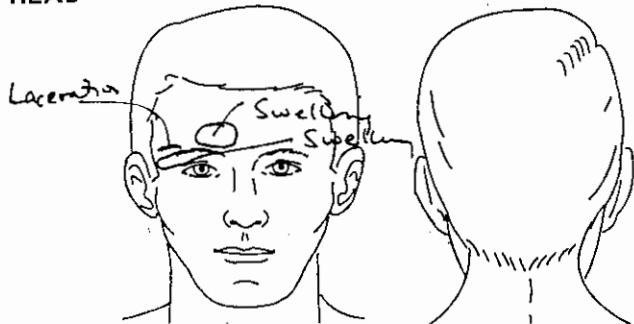
☐ home ☐ school☐ neighbor's ☐ city park☐ work ☐ street

Altercation

context:

☐ fell ☐ direct blow ☐ incised wound ☐ stab wound ☐ burn☐ ? fall ☐ ? hit ☐ objectLOC? ☐ no ☐ dazed ☐ yes duration: brief SecondIF YES, remembers: ☒ injury ☒ coming to hospitalROS ☒ vomiting ☒ headache ☒ neck painPAST HISTORY ☒ negativeMeds- ☒ none / ☐ see nurses noteAllergies- ☒ NKDA / ☐ see nurses note☒ Nurses note reviewed ☐ Tetanus immun. current ☒ Vital signs reviewedPHYSICAL EXAM ☒ Alert ☐ LethargicDistress- ☐ NAD ☐ mild ☐ moderate ☐ severeOther- ☐ c-collar (PTA / in ED) ☐ back-board ☐ IV ☐ splint

HEAD



NECK

☒ non-tender☒ painless ROM

see diagram

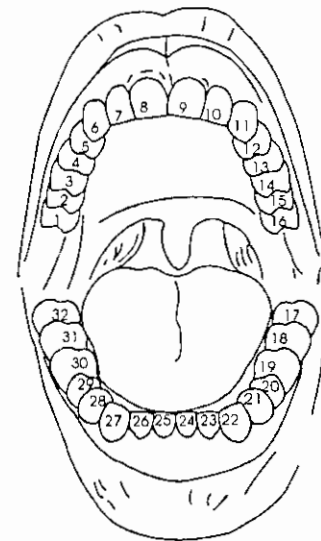
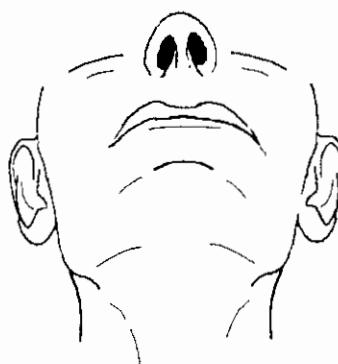
vertebral point-tenderness

EYES

☐ lids / conjunctivae☐ normal☒ PERRL☒ EOMI☐ periorbital hematoma☐ subconjunctival hemorrhage☐ foreign body☐ corneal abrasion☐ hyphema☐ retinal detachment☐ unequal pupils

R pupil ____ mm L pupil ____ mm

ENT


☒ normal external☒ pharynx nml☒ no injury to teeth
lips or gums☐ hemotympanum☐ nasal septal hematoma☐ TM obscured by wax☐ clotted nasal blood☐ dental injury☐ dental malocclusion

T=Tenderness PtT=Point Tenderness S=Swelling E=Ecchymosis B=Burn
 C=Contusion Lac=Laceration A=Abrasion M=Muscle spasm
 PW=puncture wound (Ø=without m=mild mod=moderate sv=severe)
 Example- Tsv = Tenderness on palpation (severe)


[illegible]

IV THERAPY							INTAKE		OUTPUT		
IV #1		IV #2									
Time	Site	Type	Rate	Amt ↑	Amt ABS ↓	Additive	Time	PO Amount	Urine	Stool	Ng/Emesis
TOTAL							TOTAL				


MODE OF DISCHARGE: ☐ WALK ☐ W/C ☐ CARRY ☐ STRETCHER TIME _____ RN NOTE COMPLETE ☐




0
No Hurt




2
Hurts Little Bit




4
Hurts Little More



6
Hurts Even More



8
Hurts Whole Lot



10
Hurts Worst

INITIALS	SIGNATURE	INITIALS	SIGNATURE
<i>BN</i>	<i>B. G. M.</i>		


Tufts-New England Medical Center

The Walter M. and Dorsey S. Cabot Emergency Department

Weight: _____ kg

Allergies: _____

208 77 16

AC 61264043

WILLIAM MARLOW

IAA STEPHEN. JAMES

09/19/1976

02/04/03

EMERGENCY DEPARTMENT ORDERS

MD/PA Initials /Time	Medication or IV Fluids	RN Initials /Time	Sec Initials /Time	MD/PA Initials /Time	Labs/Tests/Other Orders	RN Initials /Time	Sec Initials /Time
	<input type="checkbox"/> IV Solution _____				<input type="checkbox"/> CBC <input type="checkbox"/> Diff		
	<input type="checkbox"/> Add to 1st/every liter: _____				<input type="checkbox"/> LBCG <input type="checkbox"/> LFTs <input type="checkbox"/> Amylase		
	<input type="checkbox"/> Bolus: _____ cc				<input type="checkbox"/> Urine Dip <input type="checkbox"/> UA <input type="checkbox"/> Urine C&S <input type="checkbox"/> UCG		
	<input type="checkbox"/> then rate: _____ cc/hr; Total: _____				<input type="checkbox"/> CPK <input type="checkbox"/> CK-MB <input type="checkbox"/> Troponin		
	<input type="checkbox"/> Saline Lock				<input type="checkbox"/> PT/INR <input type="checkbox"/> PTT		
	<input type="checkbox"/> Td				<input type="checkbox"/> Blood C&S # sets: _____		
	Other Medications or Fluids:				<input type="checkbox"/> Urine Tox <input type="checkbox"/> Serum Tox <input type="checkbox"/> EtOH		
					<input type="checkbox"/> Other Drug Levels: _____		
					<input type="checkbox"/> Rapid Strep <input type="checkbox"/> Other C&S: _____		
					<input type="checkbox"/> FS HgB <input type="checkbox"/> FS Glucose		
					<input type="checkbox"/> Blood Bank Tests:		
					Other Labs:		
					<input type="checkbox"/> ECG indication: <input type="checkbox"/> Card Monitor		
					<input type="checkbox"/> Pulse Ox		
					<input type="checkbox"/> O ₂ _____ liters; mode _____		
					<input type="checkbox"/> CXR indication: <input type="checkbox"/> Port		
					<input type="checkbox"/> C-Spine indication: <input type="checkbox"/> Port		
					Other X-Rays:		
					<input type="checkbox"/> Ace Wrap <input type="checkbox"/> "Air Cast" type splint		
					<input type="checkbox"/> Crutches <input type="checkbox"/> Cane <input type="checkbox"/> Cast Shoe		
					<input type="checkbox"/> Knee Immob <input type="checkbox"/> Sling <input type="checkbox"/> Wrist Splint		
					<input type="checkbox"/> Admit to ED Obs <input type="checkbox"/> See Add'l Orders		
init	signature	init	signature	init	signature	init	signature
MS	W. Stephens						
BA	Bela G. M. R.						



Tufts-New England Medical Center

Emergency Department
750 Washington Street
Boston, MA 02111
(617) 636-5566

PATIENT INSTRUCTION SHEET

208 77 16
AC 61264043
WILLIAMS, HARLOW
FAA STEPHEN, JAMES
02/19/1976 M
02/04/03

20403

(PATIENT IDENTIFICATION)

MEDICINES PRESCRIBED

DIRECTIONS

IN R_x

REFILLS

TO TAKE HOME

Tylenol 650mg Take 2 now → #7

FOLLOW UP WITH:

- ☒ YOUR REGULAR DOCTOR OR CLINIC
☐ THROUGH YOUR HMO
☐ RETURN TO OUR EMERGENCY DEPT.
☐ SEE NEMCH PHONE LISTING
☐ OTHER

WHEN YOU SHOULD FOLLOW UP:

- ☐ TOMORROW
☐ CALL NEXT BUSINESS DAY TO ARRANGE APPOINTMENT
☐ CALL NEXT BUSINESS DAY TO TALK WITH DOCTOR
☒ FOR ROUTINE FOLLOW UP
☐ IF NOT FEELING BETTER WITHIN _____ DAYS
☐ OTHER

** MANY INSURANCE COMPANIES REQUIRE A REFERRAL BEFORE YOU SEE ANYONE BESIDES YOUR PCP; PLEASE CONTACT YOUR PCP **

ADDITIONAL INSTRUCTIONS

FOLLOW INSTRUCTION SHEETS
RETURN IF PROBLEMS

THE FOLLOWING HEALTH CARE PROVIDER (S) WERE CONTACTED:

☐ FAX; ☐ PHONE; ☐ E-MAIL; ☐ OTHER

ADDITIONAL INSTRUCTION SHEETS GIVEN

WORK/ACTIVITY RECOMMENDED

- ☐ RETURN TO FULL WORK, NO RESTRICTIONS
☐ MODIFIED WORK, WITH RESTRICTIONS, FOR _____ DAYS
 ☐ NO LIFTING ☐ NO LIFTING MORE THAN _____ LBS.
 ☐ NO CLIMBING/BENDING/STOOPING
 ☐ NO STANDING/WALKING
 ☐ NO DRIVING OR OPERATING MACHINERY
 ☐ LIMITED USE OF: _____
☐ OUT OF WORK/SCHOOL FOR _____ DAYS

WE APPRECIATE THAT YOU CHOSE NEW ENGLAND MEDICAL CENTER FOR YOUR CARE. BECAUSE THE EVALUATION AND TREATMENT YOU RECEIVED TODAY WAS PROVIDED ON AN EMERGENCY BASIS, WE RECOMMEND THAT YOU FOLLOW TODAY'S VISIT BY CONTACTING YOUR PRIMARY CARE PROVIDER (PCP) FOR FURTHER CARE. IF YOU NEED A REFERRAL TO A PCP PLEASE ASK US TO HELP. CALL AND/OR SEE YOUR PCP AS SOON AS POSSIBLE, AS WELL AS ANY SPECIALISTS WE HAVE RECOMMENDED. IF THERE ARE ANY DIFFICULTIES REACHING YOUR PCP OR SPECIALIST, OR YOUR CONDITION UNEXPECTEDLY WORSENS, PLEASE CALL US, RETURN, OR SEEK MEDICAL ATTENTION AT YOUR CLOSEST EMERGENCY DEPARTMENT. WE ARE AVAILABLE TO SERVE YOU 24 HOURS A DAY.

IF YOU HAD X-RAYS THEY WILL BE REVIEWED BY A SPECIALIST WITHIN A FEW DAYS. IF THERE IS A CHANGE IN THE READING, OR IF UNEXPECTED FINDINGS IN OTHER TESTS DEVELOP, WE WILL ATTEMPT TO NOTIFY YOU. MAKE CERTAIN THAT WE HAVE YOUR CORRECT ADDRESS AND PHONE NUMBER.

FOR A COPY OF YOUR EMERGENCY RECORD CONTACT OUR MEDICAL RECORDS DEPARTMENT (636-6300) DURING REGULAR BUSINESS HOURS.

THESE INSTRUCTIONS HAVE BEEN EXPLAINED TO ME AND I UNDERSTAND THEM.

PATIENT (OR GUARDIAN)

SIGNATURE: X Marlow Williams

(RELATIONSHIP)

STAFF MEMBER EXPLAINING

INSTRUCTIONS: Marlow Williams
DISCHARGE TIME

NEMCH PHONE NUMBERS

(USUALLY MON. - FRI., 8:30 a.m. - 4:30 p.m.)

PRIMARY CARE

PAIN MANAGEMENT 636-7246
GENERAL MEDICAL ASSOCIATES (GMA) 636-9770
GENERAL PEDIATRICS 636-5255
OB/GYN 636-5886

SPECIALITY CARE

ORTHOPEDICS 636-5268
HAND SURGERY 636-5682
EAR/NOSE/THROAT 636-5496
OPHTHALMOLOGY 636-5743
DERMATOLOGY 636-0156
GENERAL SURGERY 636-6318
UROLOGY 636-6317
DENTISTRY 636-5472
NEUROLOGY 636-5848
REHAB. MED 636-5634
OTHER 636-
MAIN HOSPITAL NUMBER 636-5000

Williams, Marlow

Sex:M

BD:09/19/1976

MR#:C00002087716

CT FACE W/O CONT

Feb 04, 2003 22:02

C 573A-020403 CT ORBIT -SIGNED

**** FINAL DIAGNOSTIC REPORT ****

***** FINAL DIAGNOSTIC REPORT

Patient Name: WILLIAMS, MARLOW

Med Rec #: 2087716

Referring Physician: STEPHEN, JAMES 311

Exam Date: 04-Feb-2003

Exam Status: SIGNED

Exam: CT ORBIT

Clinical data:

REASON 1: RIGHT ORBIT

REASON 2: R/O FX

REASON 3: BLUNT TRAUMA RIGHT EYE

Report:

CLINICAL HISTORY: Trauma.

TECHNIQUE: 1 mm sequential axial and direct coronal imaging of the orbits performed as per departmental protocol.

FINDINGS: Minimal mucosal thickening is noted involving the right frontal sinus. A left frontal sinus osteoma is also seen.

No orbital fractures are identified on the available images.

The globes are intact.

Incidental note is made of a left nasal septal spur.

Soft tissue swelling is seen in the periorbital region, as well as over the temporal areas, right greater than left.

Note is also made of a frontal sinus bulla.

Impression:

1. Left frontal sinus osteoma.
2. Minimal mucosal thickening, right frontal sinus.
3. Frontal sinus bulla.
4. No fractures identified.
5. Soft tissue swelling as detailed above.
6. Globes are intact.

signed: Mohammed Ayadi, M.D.

In accordance with department policy, as teaching physician, I have reviewed all images, and edited the report as required.

cosigned: Barbara L. Carter, M.D.